



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name

TRAVELERS INDEMNITY CO

MFDR Tracking Number

M4-16-3151-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

JUNE 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "64702-was denied as bundled however this procedure was billed because the patient had dense numbers in that distribution but the nerve was not cut, it was scarred. Yes, this procedure was done through the same incision however that is because it was performed on a finger so only one large incision was necessary."

Amount in Dispute: \$1,677.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the Medicare coding edits which state that reimbursement for CPT code 64702 is included in the reimbursement for the primary procedure, here CPT code 26356. The Provider alleges that the addition of the -XU modifier, which indicates an unusual non-overlapping procedure, entitles them to reimbursement. There is no evidence in either their position statement or the operative report that explains why the neurolysis, which was performed through the same incision and in conjunction with the tendon repair, qualifies as an unusual non-overlapping procedure. As the Provider has failed to substantiate the use of the modifier, the documentation does not support that separate reimbursement is due for CPT code 64702. The Carrier contends the Provider is not entitled to additional reimbursement"

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2016	CPT Code 64702-XU-51-F2 Neuroplasty; digital, 1 or both, same digit	\$1,677.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P12-Workers compensation jurisdictional fee schedule adjustment.
 - 59-Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
 - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
 - 78-The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
 - 86-Service performed was distinct or independent from other services performed on the same day.
 - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
 - W3-Additional payment made on appeal/reconsideration.

Issues

Is the allowance of CPT code 64702-XU-51-F2 included in the allowance of another service/procedure billed on the disputed date of service?

Findings

According to the explanation of the respondent denied reimbursement for CPT code 64702-XU-51-F2 based upon reason code "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

On the disputed date of service, the requestor billed codes 26356-F2, 26356-XS-51-F2, and 64702-XU-51-F2.

CPT code 64702 is defined as "Neuroplasty; digital, 1 or both, same digit." The requestor appended modifiers "XU-Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service," "51-Multiple Procedures," and "F2-Left hand, third digit."

CPT code 26356 is defined as "Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon." The requestor appended modifiers "XS-Separate structure, a service that is distinct because it was performed on a separate organ/structure," "51-Multiple Procedures," and "F2-Left hand, third digit."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per CCI edits, CPT code 64702XU-51-F2- is a component of 26356; however, a modifier is allowed to differentiate the service. The requestor appended modifier 51, F2 and XU to code 64702 and 51, F2 and XS to code 26356. The Division reviewed the Operative report and finds that both procedures were performed to the right middle finger zone 2 through same incision. The Division finds that the respondent's denial based upon reason code "97" is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	11/10/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.